EXHIBIT 2

Transcript for CDC Telebriefing: Guideline for Prescribing Opioids for Chronic Pain

Press Briefing Transcript

Tuesday, March 15, 2016, 12:30am EST

- Audio recording [MP3, 7.2 MB]

Please Note:This transcript is not edited and may contain errors.

OPERATOR: Good afternoon, everyone. Thank you for standing by. Please continue holding, our conference will begin momentarily. Thank you all for standing by. Please continue holding. We will begin our conference momentarily.

OPERATOR good morning. Thank you for all standing by. Welcome to today's conference call. At this time, all lines are on listen only mode for today's conference. Until the question and answer portion of our call at which time you'll be prompted to press star 1 on your touch tone phone. Please limit yourself to one question and one follow-up during the Q and A portion of the call, please be sure to announce your name. Our conference is being recorded, if you have any objections you may disconnect at this time. I will now turn the conference over to your host Mrs. Kathy Harben. Ma'am you may proceed.

KATHY HARBEN: Thank you, Jill. Thank you all for joining us for the release of the CDC guideline for prescribing opioids for chronic pain. We're joined today by CDC Director by Dr.Tom Frieden. Dr.Debra Houry who is Director of CDC's National Center for Injury Prevention and Control, and Dr.Deborah Dowell, co-author of the guideline are here for the question and answer session. In addition, we welcome the Secretary Of Health And Human Services Sylvia Mathews Burwell for opening remarks. I'll now turn the call over to Dr.Frieden to introduce Secretary Burwell.

DR. FRIEDEN: Thank you and good afternoon. We're delighted that secretary Burwell could join us today. One year ago in march 2015 secretary Burwell announced HHS initiative to reduce the prescription opioid and heroin related overdose death and dependence. Secretary Burwell understands well the devastation that opioid abuse and overdose has caused for American families and communities and has helped to bring together stakeholders from across the country to focus on prevention, treatment and intervention. Secretary Burwell.

SECRETARY BURWELL: Thank you so much, Dr.Frieden. The opioid epidemic is one of the most pressing public health issues in the United States today. Last year, more Americans died from drug overdoses than car crashes. And these overdoses have hit families across our entire nation. Families who live on city blocks and families who live in

rural towns. In my own home state of West Virginia, I have seen firsthand and continue to see firsthand how substance use can devastate families and communities. Combatting the opioid epidemic is a national priority. That's why the President's budget requests more than $1 billion to fight opioid use disorder and overdose, and we look forward to working with the congress to secure this funding. It's why governors throughout the nation are working from common ground to end this crisis. And it's why public health leaders across the country are finding innovative ways to push back against these troubling statistics and what it means to people in their everyday lives. At HHS, we're helping to lead the nationwide effort by focusing on three priority areas. First, we want to make sure that naloxone is in the hands of first responders and anyone else who responds to an opioid overdose.

In November, the FDA approved a nasal form of Naloxone, one of the more innovative ways to get this treatment to the people who need it most. We're also expanding access to evidence-based treatments like medication -assisted treatment. A combination of behavioral therapy and counseling with medication to treat substance use disorders. And last week, we awarded $94 million to medication-assisted treatment in 271 health centers across the country. Third, what brings us here today is our commitment to equip health professionals with tools they need to fight this epidemic. We need to help primary care providers make the most informed prescribing decision. Balancing the need to manage their patient's chronic pain with the duty to curb dangerous prescribing practices. That's why CDC is releasing their guideline for prescribing opioids for chronic pain. We believe this guideline will help health care professionals provide safer and more effective care for patients dealing with chronic pain. And we also believe it will help these providers draw down the rates of opioid use disorder, overdose and sadly, ultimately death. We know this is a goal that we all share. Patients with chronic pain should have safe and effective pain management. And too many families have had to come to grips with the tragedy of opioid use disorder and overdose. The guideline CDC is releasing today will provide safer pain management while helping us reduce opioid abuse. It's an important step in our work to combat the opioid epidemic. With that, I'll turn it back to Dr.Frieden.

DR. FRIEDEN: Thank you so much, Secretary Burwell. It's become increasingly clear that opioids carry substantial risks, but only uncertain benefits, especially compared with other treatments for chronic pain. Today and every day this year, more than 40 Americans will die from a prescription opioid overdose in this country. Beginning treatment with an opioid is a momentous decision. And it should only be done with full understanding by both the clinician and the patient of the substantial risks and uncertain benefits involved. We know of no other medication that's routinely used for a nonfatal condition that kills patients so frequently. With nearly 250 million prescriptions written each year, it's so important that doctors understand that any one of those prescriptions could potentially end a patient's life. A study in 2015 found that 1 out of every 550 patients started on long-term opioid therapy for non-cancer pain died of an opioid-related cause, just a little over– within 21/2 years of the first prescription. Remarkably those who got the highest doses of opioids, more than 200 MMEs per day had a 1 in 32 chance of dying in just 21/2 years. And while some opioids potentially Buprenorphine and others may carry a slightly lower risk of dependence, almost all the opioids on the market are just as addictive as heroin. And while it's important that abuse deterrent formulations be made more widely available because those formulations are harder to melt down and then inject, they don't prevent opioid abuse or overdose when taken by mouth. The bottom line is that increased prescribing of opioids which has quadrupled since 1999 is fueling an epidemic that's now a blurring of the lines between prescription opioids and illicit opioids. I want to be clear that prescription opioids have an important place in pain management when the potential benefits outweigh the potential harm. Many Americans use prescription opioids for much needed relief from pain. And evidence support that opioids can be effective in the short term.

They're important medications, for example, for patients after cancer treatment or getting end of life or palliative care. But we don't have evidence to show that opioids can control chronic pain effectively over the long term. And we do have evidence that other treatment such as exercise therapy, nonsteroidal inflammatory drugs and a variety of other treatments and modalities can be effective for chronic pain with far lower risks. That's why today CDC is releasing the CDC Guideline for Prescribing Opioids for Chronic Pain. To chart a safer, more effective course. The goal of the new guideline is to help providers improve patient care and safety and prevent opioid overdose. The guideline reflects the best available research to date and will refine the guidance as new science becomes available. But the ongoing impact of prescription overdoses and effect on American lives, families and communities means that we have to act now. The guideline was developed to support primary care clinicians who prescribe about half of all opioid pain medications in relieving patient's pain, preventing patient's suffering, and promoting patient's well-being. This guideline helps by offering a flexible tool. Not a one size fits all tool but a flexible tool to support informed clinical decision making, encourage improved communication between clinicians and patients and improve clinician confidence about when and how to use opioids to manage chronic pain. The guideline provides information about safer and effective options for pain management and encourages clinicians to work with other providers, including behavioral health specialists, pharmacists and pain management specialists. The guideline is intended to address chronic pain, not acute pain. But we recognize based on the feedback we got from doctors and others that long-term opioid use often begins with treatment of acute pain and the guideline suggests that clinicians prescribe the lowest effective dose of immediate release opioids when treating a patient with acute pain and not prescribe more than is needed. Three days or less will often be sufficient. More than seven days will rarely be needed for most acute pain syndromes.

The guideline is designed to help clinicians and patients together assess the risks and benefits of opioid use and identify the best treatment option. We work to develop a practical guideline with tools and resources, including a decision checklist, to help clinicians use the guideline every day. We want patients to understand the recommendations, so we created resources and materials for patients as well. The guideline has 12 recommendations based on three key principles. First, non-opioid therapy is preferred for chronic pain outside of active cancer, palliative and end of life care. Opioids should not be the first line treatment for chronic pain. They should only be used when their benefits are expected to outweigh their substantial risks. Second, when opioids are used start low and go slow. Start with the lowest possible effective dose and increase only gradually. Third, always use caution when prescribing opioids and monitor every patient closely. Clinicians can minimize the risk to patients by taking actions such as checking the state's prescription drug monitoring program or having a plan to taper opioids if the desired response is not achieved.

I want to spend a moment talking about the process of guideline production and preparation. CDC developed this guideline using a transparent, rigorous, scientific process. We obtained the best available evidence from anywhere in the published literature. We also involved more than 50 of the top experts in the world on various aspects of pain addiction and pain management to review the guidelines. We carefully read and considered more than 4,300 public comments, including letters from more than 160 professional, community and advocacy organizations and many individuals whose lives have been deeply touched by this issue. In the end, these are CDC guidelines. Written by CDC staff and CDC stands by them. In the feedback that we heard, we understood the importance of balancing the expected benefits and risks, and how challenging that can be. Primary care clinicians reported concerns about training and other modalities for pain management. Clinicians and patients need to carefully weigh the decision to

start opioids and proceed only when there's a full understanding of the risks. And that the benefits are likely to outweigh the risks. Plainly stated, the risks of opioids are addictions and death and the benefits for chronic pain are often transient and generally unproven. In fact, some of the literature that was shared to us in the comment phase, outlined studies that suggests that individuals treated with opioids may actually experience more pain in the medium and long term than patients not treated with opioids because of potentiation of pain. Management of chronic pain is an art and a science. The science of pioids for chronic patient is clear. For the majority of patients there are effective alternatives to the known serious and all too often fatal risks of opioids.

KATHY HARBEN: Thank you, Dr.Frieden. Jill, we are now ready for questions.

>> Thank you, Mrs. Harben. Once again, if you'd like to ask a question, please press star 1 on your touch tone phone. Please be sure to release your line so you can record your name so that i may introduce you. Also a reminder, please limit yourself to one question and one follow-up. Our first question is from Melanie Saltzman with News Hour. Your line is open, ma'am.

MELANIE SALTZMAN: Hello, can you hear me?

DR. FRIEDEN: yes, we can.

MELANIE SALTZMAN: hi, thanks for taking my question. My question is with regards to the process. I know you just addressed that but I'd like to dive in more for a minute. Why was the process so complicated in being able to come up with a concrete, comprehensive set of guidelines? What went into that and why did it take more than just a week or two weeks to really get those concrete 12 points?

DR. FRIEDEN: i think there are several factors that go into the process. The first is that the evidence on treatment of chronic pain is not as robust as we would like. There are a limited number of studies that have looked at the effectiveness for long-term pain. And those studies have generally not found effective– positive outcomes in terms of improvement in functioning or reduction in pain in the long term. Also in the process, it's been very important that we involve a broad range of stakeholders so that we can get perspectives from patients, from families, from clinicians. And then accommodate and address the concerns that we have heard. So there's– there has been both the need to make decisions based on the best available science and also the need to have an inclusive process of getting a wide range of comments to inform the final guideline.

MELANIE SALTZMAN: and then i guess the follow-up would be, in terms of making sure these guidelines are actually implemented, not only something that physicians can go to, but in a way that you're making sure that they actually are looking at these guidelines, is there a plan for doing that? Those current practicing physicians. But also in med schools, looking at the future physicians in the United States and how they're being trained.

DR. FRIEDEN: Well, first, to be very clear we are not a regulatory agency. So these are guidelines. They are recommendations. States, the national governors' association, health care systems, insurers may look to these guidelines, when they implement policies within their own jurisdictions or institutions but what our role is to provide the best available science to try to improve the care of patients who are suffering from chronic pain which is a very challenging situation for patients to have to live with and a very challenging condition for physicians to treat.

MELANIE SALTZMAN: Thank you.

DR. FRIEDEN: We also, I will say, did work with others to develop a checklist for prescribing opiates for chronic pain. This is for primary care providers. And this and other tools will be part of the rollout process to be able to empower physicians to have this information at their fingertips.

MELANIE SALTZMAN: So, it's a suggestion for the guidelines, but not something that's going to be a requirement for physicians to follow?

DR. FRIEDEN: CDC does not regulate the practice of medicine.

MELANIE SALTZMAN: okay. Thank you so much.

OPERATOR: the next question is from Dan Childs with ABC News. Your line is open.

DAN CHILDS: Thank you very much for taking my question. I have one question and a quick follow-up. The question I have is we have pharmaceutical companies essentially manufacturers being called out specifically in a JAMA editorial having to do with these new guidelines. My question is, what part, , did pharmaceutical companies play here, if any, as a stakeholder in developing these guidelines? and what is the responsibility going forward, seeing as there are many who believe that they hold a great deal of responsibility in terms of the expanded use of these drugs for those with chronic pain?

DR. FRIEDEN: So, we exercised very stringent conflict of interest policy, whereby we did not involve in the drafting of the guidelines anyone who had a conflict of interest with pharmaceutical industry or other actors in this topic. We certainly read and considered all comments received, regardless of where those were from, including some groups that are part of or associated with the pharmaceutical industry. I think we can take a step back and say that pain in general, and chronic pain specifically, is a very challenging condition to treat. And for many years, status of medical practice in the U.S.was such that pain was not adequately addressed. And there are still patients whose pain is not adequately addressed. The challenge is when we generalize that situation to chronic pain in which opioids are of unproven benefit, we can get into really big problems. Because these medicines are so addictive and they are so lethal. I think some of the things, the pharmaceutical industry has done include formulations which make it harder to melt down and shoot up these drugs. I do think it's important to be clear that these formulations which are referred to as abuse deterrent are no less addictive. And unfortunately, no medication has yet been discovered that can separate the pain relieving efficacy of an opioid from the addictive nature of an opioid. And that would be a really great thing, if a company can come up with that because then you would have an effective pain relief medication that is significantly less addictive than heroin. Right now, we don't have that. And in the interim, i think it will just be very important and one of the things we heard from physicians was they wanted guidelines that were clearly non-conflicted, and that's what these are.

DAN CHILDS: The one follow-up that I have, is there any clue as to what proportion of 250 million prescriptions per year are going to those with chronic pain? i.e., not those who are cancer patients or those who are taking them to palliative care.

DR. FRIEDEN: let me turn this over to Dr.Deborah Dowell. Dr. Dowell is the lead author of the guideline and spent an enormous amount of work probably understands the literature on this topic better than anyone alive..

DR.DEBORAH DOWELL: so, in answer to your question, the literature supports that a minority of patients receiving opioids are receiving them for chronic, for long-term use for chronic pain, about 5 percent. However, when you look at the amount prescribed in terms of days, duration, for a majority of amount of opioids prescribed,

about 70 percent. They also account for a disproportionate share of the adverse effects related to opioids. One study national VA. Sample found that more than 70 percent of patients dying of opioid-related overdose were prescribed opioid were being treated for chronic pain conditions. In addition, there's evidence patients who develop opioid use disorder, were prescribed opiods a proportionate amount of them are chronic pain.

DAN CHILDS: About 5% of patients accounting for 70% of these prescriptions?

DR.DEBORAH DOWELL: Yes, some studies have found that.

DR. FRIEDEN: And this is one of the reasons why we have also addressed use of opioids to treat acute pain. Because most of the treatment– most of the patients who go on to chronic pain syndrome, start with an acute pain situation. Next question, please.

OPERATOR: The next question is from Robert Lowes with Medscape medical news. Your line is open.

ROBERT LOWES: Thank you for taking my call. Dr.Frieden, there were strenuous objections to the initial set of 12 recommendations as regards to specific numbers on, for instance, you know, a dose threshold. 90 MME being something you should avoid. And the number of days that were suggested for the duration and several medical societies felt that they didn't want any specific numbers because there wasn't enough evidence. Yet, the final recommendations pretty much preserve what was in the initial ones in regards to these specific numbers. So what went into the thinking, you had objections to numbers that doctors felt might constrain them and weren't evidence-based.

DR. FRIEDEN: i will say we did get a lot of comments in. We took them all seriously. We found many of them helpful. And between the earlier released version and the final, there are a number of refinements in the approach. That includes the two areas that you mention, involving lowest effective dose and shortest duration. We have provided a range, rather than a fixed number I'll let Dr. Deb Houry who is the Director of The National Center for Injury Prevention And Control in which this work resides comment further. Dr. Houry.

DR. DEBORAH HOURY: Thank you. There were comments on both sides. We have a lot of organizations who actually thought we should have lower dosages or shorter durations. So there was a balance of both shorter and longer. With regards to the actual dosage, we tried to apply more nuances. You'll see that in the full document. At 50 MME we actually carefully reassess the patient's benefits and risks. At 90 MME, we say there's a clear cap but you should justify the decision. And then it talks about referring to a pain specialist. When you do look at a lot of the emerging evidence, though, there is evidence of increase overdose as the dose escalates. Providers did want a number in general to guide their practice. Again, this is guidelines not regulatory, so this will help physicians in their daily practices to determine what safe dosages. And this is about initiation of opioids for those doses. We feel strongly that you do not initiate an opioid naive patient on a high level of opioid because of the substantial risk of overdose. As Dr.Frieden mentioned, we did provide a range and that was modification we did after the feedback for the acute pain recommendation. We think it's important that physicians to always use the shortest course possible but did want to allow more flexibility in that number.

DR. FRIEDEN: Thank you. Next question.

OPERATOR: The next question is Randall Pearson with Reuters. Your line is open.

RANDALL PEARSON: Hi there, Dr. Frieden. I was just wondering your thoughts about common sense among the federal agencies, the FDA and CDC. You mentioned that the prescriptions have quadrupled since 1999, leading to 165,000 overdoses. But should the CDC and FDA exercised more common sense in recent years. Have you left the cows out the barn? When you might have been able to constrain the situation earlier. For example, Hydro, an extremely potent opioid was approved by the FDA fairly recently despite what we know about the heroin addictions throughout America and their links to opioids. Has the federal government really lapsed in trying to be more proactive earlier to prevent this situation from being at this incredible degree?

DR. FRIEDEN: Unfortunately, i think there's no quick fix for the opioid epidemic. We're seeing a situation in which a large number of people in this country are already addicted or dependent. And that involves both prescription opioids, and illicit opioids, heroin and illegally produced Fentanyl among other products. And the challenge really is turning around our approach to pain management. Understanding that the best treatment isn't always the one that provides the most immediate relief. It's the one that provides the best relief for the longest period of time. That's something that i think as a medical profession and as a society we had insufficient recognition of. And we're paying the price. Far too many families and individuals are suffering or dying for that reason. So, we can always look back and say something could have been done sooner or differently. Our focus right now is moving forward. What can we do to protect as many people as possible? And prevent as many overdoses, deaths and people who become dependent and addicted to opioids as possible going forward.

RANDALL PEARSON: Shouldn't there be more stringent requirements in the future at the FDA, since we have this flood of drugs in the market which we can't control? Should the FDA be a little more vigilant or restrictive itself in putting yet more products on the market?

TOM FRIEDEN: I think you'd have to address that question to the FDA. The FDA by law have to basically make decisions based on whether medications are safe and effective and equivalent to medications on the market. There may not be a regulatory method for them to do what you're suggesting, and whether that would be advisable or not I can't comment. Next question, please.

OPERATOR the next question from Mehmat Oz with "The Dr.Oz Show." Your line is open. Dr.Oz, your line is open for your question. Your line is open.

TOM FRIEDEN: shall we go on to the next question?

OPERATOR: Moving on to the next question. It's from Kimberly Leonard with "U.S. News and World Reports." Your line is open, ma'am.

KIMBERLY LEONARD: yes, hi, thank you for taking my call. One of the items here on the guidance talks about using a urine test to detect whether patients already have signs of opioids in them. And obviously that's to tell whether they might be selling them and not using them or if they already have it detected there. My question is this something that physician, are already doing, or is this something that's new? And if opioids are detected, would a doctor then have enough information to say we're not going to be prescribing this?

TOM FRIEDEN: So, I will turn this over to Dr.Dowell.

KIMBERLY LEONARD: okay.

DR.DEBORAH DOWELL: This CDC guideline is certainly not the first guideline to recommend this. That being said, we did find surveys that many physicians do not use urine drug testing in making decisions about prescribing opioids. And in addition to that, a couple of studies have found that physicians misinterpret results on urine drug testing. Urine drug tests can't tell you everything; they can tell you whether in many situations whether a prescribed drug is present or whether other drugs are present. They can't tell you anything about the dose. And the guidelines does provide further interpretations for these tests.

KIMBERLY LEONARD: okay, thank you.

TOM FRIEDEN: Next question, please.

OPERATOR: the next question is from Mehmat Oz with "The Dr.Oz Show." Your line is open.

TOM FRIEDEN: If you're speaking, we can't hear you.

MEHMAT OZ: Hello.

TOM FRIEDEN: Yes, go ahead.

MEHMAT OZ: oh, good. Sorry about that. For the average patient who hears all of this news, when they're offered an opiate by their physician, what would you recommend they push back on? How would they phrase and articulate their medicines to take an opiate?

TOM FRIEDEN: That's a great question, I'll startand i would ask Dr.Dowell to continue. I would first say, is this necessary, what are the alternatives, what are the risks, what's the dosage? And can you guarantee me that this is going to relieve my pain and not risk getting me addicted. Dr.Dowell.

DR.DEBORAH DOWELL: I would agree with that 100%. I think the important questions are, you know, is this necessary, what are the alternatives? What are the risks? What are the benefits? And how long do you anticipate that I'm going to be taking this? One more i would add is, what do we hope to accomplish? What should be our goals in using this medication and how are you going to know that we accomplish them.

DEB HOURY: And this is Deb Houry just to add, the first principle of our guidelines are about use non-pharmacological therapy and non-opiate pharmacological therapy. All of us speaking today are physicians who worked in the field. And many of us didn't have a lot experience of what are the non-opioid alternatives. I think patients need to ask their doctors what the non-opioid alternatives are and have a better understanding of how those can impact their pain directly.

MEHMAT OZ: As a quick follow up, Tom you articulate in your New England Journal piece about prescribing an opiate per person in America. What's the goal? There's a discrepancy from state to state that's quite dramatic? Any idea what you hope to see in three years, five years?

TOM FRIEDEN: Really what we hope to see is fewer deaths from opiates all sorts of opiates. Both legal and illegal. That's the bottom line here. What we also hope to see in a more immediate basis is that some of the higher and more dangerous doses of opiates will be used much less. I was really stunned at the study that shows that 1 out of 32 patients died in 21/2 years from the highest doses of opiates. So understanding these are really dangerous medications which carry the risk of addiction and death. And that we would at least begin to see that prescriptions that are written are safer, or less risky, at least. Ultimately, we want to see the number of deaths come down. It's

just a horrific fact that we're seeing it continue to increase. It's one of the very few trends in this country where health is getting worse. It's one of the very few things where we're seeing increase in mortality rates; and we're seeing it across the entire lifespan – from neonatal abstinent syndrome to kids who get hooked on an opiate because of a sports injury and end up getting Hepatitis C or HIV because they switched to injecting drugs to elderly who have increased risk of falls because they're on opiates. It's a terrible problem. It's going to involve all of us getting into a more appropriate place when we think about managing pain.

MEHMAT OZ: thank you.

TOM FRIEDEN: thank you.

OPERATOR: Our next question is from Charles Lane with "The Washington Post." Your line is open.

CHARLES LANE: Thank you. Listening to you speak about these prescription drugs, I'm just struck at the change in tone, the depiction of these as Dr.Frieden's own words as a dangerous quote/unquote drug. It's far, far from what we're being told about them 15 or 20 years ago when they came on the market. So, I'm wondering the following, a lot of people in the field believe there's pressure, has been pressure on physicians to prescribe these, because they would get bad reviews on Yelp or because the facilities that they work for would be thought of as neglecting pain, as the famous, you know, vital sign. How will these guidelines, and how should they affect that dynamic where there's been so much pressure on physicians, sort of when in doubt prescribe. How are you going to affect that dynamic?

TOM FRIEDEN: When i went to medical school we had exactly one lecture on pain. And in that lecture the professor said if you give an opiate to a patient in pain they will not get addicted. He was completely wrong. But a whole generation of physicians went through training hearing that. And also recognizing that pain was and continues to be undertreated in some situations. All of us have a role to play. I don't think doctors alone, I don't think patients alone, can get us to a better place. When we've interviewed patients, we've heard consistently that they're concerned about the addictiveness and danger of opiates. When we've interviewed doctors, we've heard that they're concerned that patients may be rating them poorly if they don't provide pain medications or opiates. And we know that sometimes, a few highly vocal patients may change the perception of a situation for a doctor. That's why we're emphasizing both the need to be careful with prescription of opiates and the need to scale up treatment of addiction which is a serious disease for which there are medications such as Buprenorphine and Methadone which do improve outcomes and that's part of this as well. I don't think there is a quick fix, but I do think the solution is going to involve more than just doctors and more than just patients to address the real concerns that people have about the use and risks of opiates. Next question.

OPERATOR: Next question is from Sabrina Tavernise with "The New York Times." Your line is open.

SABRINA TAVERNISE: Hi, thanks for taking the question. Dr.Frieden, I know these are your guidelines and nonbinding but it sort of sounds like you're saying in here and kind of the federal government is saying that the risks outweigh the benefits of these drugs for most patients. Is that– would you say that?

TOM FRIEDEN: I think, again, this is not a cookbook. Clinical care is both a science and an art. And there are some patients for whom currently on opiates or potentially in severe pain for whom they may be appropriate. But for the majority of patients, the risks will outweigh the benefits for chronic pain. For the vast majority of patients.

KATHY HARBEN: We have time for one more question.

OPERATOR: It comes from Sarah Karlin-Smith with Politico. Your line is open.

SARAH KARLIN-SMITH hi, is this Sarah. Thank you for taking the call. At the end of these guidelines, my question is directed to Secretary Burwell or someone at HHS if they are still on the call. You guys mentioned the need to work with other areas of federal government on policy that could make these guidelines more practical for doctors to follow. Are there any plans like for CMS or other agencies within the federal government to change how you guys cover non-opioid treatments to make it easy for physicians to offer patients non-opioid options?

TOM FRIEDEN: I don't know that others from HHS are on the call at present.. I know we've had a series of discussions with CMS and others parts of HHS about this issue. We've heard the concern from both physicians and patient groups, and we're encouraged by the progress that we've seen in a variety of insurance programs of expanding the scope of the non-pharmacological treatments provided. Dr.Houry, do you want to say anything about this?

DEB HOURY: I think these are just the next steps. I think by showing CDC's views, using the best available science on the need for non-opioids, the need for safe prescribing this will help inform a lot of future changes. And, as Dr. Frieden mentioned, we've been working closely with HHS agencies to really have a collaborative approach in making sure that we are able to provide this.

TOM FRIEDEN: I'll close the telebriefing with a final comment about the guideline and its potential to reduce the epidemic we're living through of opioid overdose deaths. The prescription overdose epidemic is doctor-driven. It can be reversed in part by doctor's actions. The guideline doesn't replace clinical judgment but it does provide a clear balance that has been missing. Prescription opioid overdose deaths can be prevented by improving prescribing practices. We can protect people from becoming addicted to opioids and clinicians are key to helping to reverse the epidemic. The management of chronic pain is both an art and a science. But the science of opioids for chronic pain is clear. For the vast majority of patients, the known, serious and all too often fatal risks far outweigh the unproven and transient benefits and there are safer alternatives. In medicine we take an oath to above all do no harm. And for chronic pain, a doctor has to go to a pretty high bar to see that the likelihood of doing harm will not be greater than the likelihood of doing good. At heart of the guidelines is a conversation between clinicians and patients about the best, safest treatment for chronic pain with a full understanding of risks and benefits. Thank you very much.

KATHY HARBEN: Thank you, Dr.Frieden. And also thank you to Dr.Houry and Dr.Dowell for joining us today. As well as Secretary Burwell. Thank you also, reporters, for follow-up questions, please call 404-639-3286. Or e-mail us@media@cdc.gov.

OPERATOR: that concludes today's conference. We thank you for participating. You may disconnect. And have a great rest of your day.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (http://www.hhs.gov/)

Subscribe to CDC Media e-mail (https://service.govdelivery.com/service/subscribe.html?code=USCDC_1_3&login=&origin=https://www.cdc.gov/media/index.html)

Syndicate Media on Your Site (http://tools.cdc.gov/syndication/)

CDC Quick Links

Data & Statistics

Freedom of Information Act Office

Public Health Image Library (PHIL) (http://phil.cdc.gov)

File Formats Help:

How do I view different file formats (PDF, DOC, PPT, MPEG) on this site? (https://www.cdc.gov/Other/plugins/)

(https://www.cdc.gov/Other/plugins/#wmv)

Page last reviewed: March 16, 2016 (archived document)

Content source: Centers for Disease Control and Prevention (/)